Delta Doctors Program

National Interest Waiver Review Checklist

Date Received:	
Reviewer:	
Review Start Date:	
Support Letter for File:	
Shipping Label for File:	
Date Letter Sent to Attorney:	

Physician's Name: _____

DOS Case Number: _____

DOB: _____

Current Address: _____

_____

Country of Birth: _____

Last Permanent Residence of: _____

Specialty: _____

Worksite Name & Address: _____

_____

_____

MUA Number: _____

HPSA Number: _____

County/Parish: _____

**Provide additional worksites with MUA/HPSA numbers on a separate page.*

Attorney: _____

Firm Name: _____

Attorney Address: _____

_____

Attorney Phone Number: _____

Attorney Fax Number: _____

Attorney Email: _____

Employer's Name: _____

Employer Contact: _____

Employer's Address: _____

_____

Employer Phone Number: _____

Employer Fax Number: _____

Employer Email: _____

_____ 1 Letter of Opinion from Legal Representatives

_____ 2 Employer's Letter

_____ 3 Physician's Statement

_____ 4 Copy of Executed Contract

- _____ Signed/dated by Physician/Employer
- _____ 5 Year (NIW)
- _____ 40 Hours per week or 160 hours per month of direct patient care
- _____ Service to Medicaid/Meidcare/Indigent Patients
- _____ Base Salary: _____
- _____ Name of each worksite and address

_____ 5 Copies of Diplomas, licenses or applications for licenses

- _____ State medical license or applicaton for license
- _____ USMLE Scores

_____ 6 Complete passport (Verify all pages)

- _____ I-129 Immigration Petition Approval Notice
- _____ H-1B Approval Notices
- _____ Copy of I-94

Summary of Reviewer's Findings: